***Jennifer E. Kelly, Psy.D.***
***Licensed Clinical Psychologist (#2267)***
833 SW 11th Suite 245, Portland, Oregon 97205
(971) 248-5050

***Welcome!*** The following information is provided for your protection and assistance in making an informed choice about treatment. It provides you with information regarding my credentials, my approach to therapy, a description of fees and services provided, and information that is important for you to know as we begin working together. Should you have questions regarding any aspect of my practice please feel free to ask me at any time.

Credentials. I am a Licensed Clinical Psychologist (#2267) in the state of Oregon. I earned my Doctorate Degree in Clinical Psychology from Pacific University in 2011. My training and professional experience includes nine years of engaging in psychotherapy and assessment with children, adolescents, adults, and couples, as well as providing services to families and groups. Currently, my focus is individual and couples psychotherapy.

Philosophy and Approach. My approach to psychotherapy is to establish a safe and warm environment where growth, awareness, and healing take place. I view psychotherapy as a valuable opportunity for clients to build upon existing strengths and learn strategies to feel better about themselves and interact more effectively with others and the world around them. Through a collaborative and supportive relationship, our work together will explore difficult experiences, thoughts, emotions, and behaviors which may be interfering with you living the life that is meaningful and enjoyable to you.

I am an integrative therapist, specifically engaging in Cognitive Behavioral Therapy, Mindfulness, Dialectical Behavior Therapy, and Gestalt with my clients. I welcome and affirm all forms of diversity!

Risks and Benefits. I engage in therapeutic methods which have been shown to be effective in research and in practice. Individual effectiveness per client is variable and cannot be guaranteed. External factors, such as events in the client's life or irregular attendance can interfere with progress. However, in my work with clients, an important part of the collaborative therapeutic relationship is to discuss ongoing progress. Accordingly, I will individualize interventions to best meet the specific needs of each client. In addition, psychotherapy is a process, suggesting that it may take time for you to "feel better" or notice differences in your life. You should know that this is not necessarily a sign that progress is not or cannot be made, but a natural part of working through the complexities of life. Please feel free to raise any questions you have regarding the treatment I am providing.

Confidentiality. The information you share with me is considered private and confidential and will not be shared with anyone unless you have given me written permission first. In this section, as throughout this document, the word "you" refers to anyone receiving services from me, inclusive of a single individual or both members of a couple. When I work with couples, all individuals attending sessions are considered clients. Therefore, in order for me to disclose any identifying information about your sessions with a third party, I need permission from all members of the client group (e.g. both members of the couple).

**Information you disclose to me is kept private, **except** under the following conditions, which are the situations that allow me to share information *without* your permission:

- If I receive first-hand information about harm done to a child or an elder
- If you tell me or I come to believe that you or someone else will be harmed
- If you commit a crime against me
- If yours or someone else's welfare appears in imminent danger
- If I am court-ordered to testify regarding my work with you
- If you have a balance due to me that is 60 days late and I need to work with a collections agency to be reimbursed for services provided to you

If you have questions about the limits of your confidentiality, please ask me.

Please see the attached Notice of Privacy Practices. This notice explains the Health Information Portability and Accountability Act (HIPAA), a federal law that provides privacy protections with regard to the use and disclosure of your Protected Health Information used for the purposes of treatment payment, and health care operations.

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Fees:

- Intake Sessions: $160 (for 60 minute first session)
- Individual Sessions: $140 (per 50 minute therapy session)
- Couple's Sessions: $140 (per 50 minute therapy session)

I occasionally have openings for reduced fee sessions, which may or may not be available at the time you receive services. Please let me know if reduced fee sessions would make therapy more financially feasible for you.

Insurance:

- I accept Aetna insurance.
- Out-of-Network services may be an option if you'd like to use insurance and do not have Aetna.

Please mention if you would like to use insurance, so we can establish your individual benefits prior to the intake.
I am happy to work with you to learn what your insurance benefits are and how we can make the most of them.

Appointments and Payment:

- Full payment or Co-pay is due at the time of each session.
- I accept check or cash as payment
- If you need to cancel an appointment, please give me 24 hours notice. If less than 24 hours notice is given, the full fee for the missed appointment will be charged. My voicemail is available 24 hours a day, seven days per week (971-248-5050).
- Please be aware that insurance will not pay for a missed session and the fee would be out-of-pocket
- You will not be charged for brief phone calls with you or others involved in assisting you (e.g. physician, previous counselor).

Please feel free to ask me any questions you may have about my fees, insurance, or payments.

Communication. Electronic communication is efficient and useful at times. I may use email, cell phone, and text messages to contact clients for scheduling as well as clinical purposes. While electronic communication has benefits, I cannot guarantee the confidentiality of communication conducted via email, text, or cellular phone. As such, by signing this agreement, you are acknowledging that you will not use these methods of communication unless you are comfortable with their limits. Emails sent to my office may become part of the client's clinical record (i.e. in the event they pertain to clinical issues and not strictly scheduling). Also, texts and voicemails exchanged will be documented in clinical record every time they pertain to clinical issues. As such, consider which mode of communication you would like to use depending on the purposes of the communication. The most confidential information should be saved for our in-person sessions.
DO NOT RELY ON AN EMAIL, VOICEMAIL, OR TEXT IF YOU ARE EXPERIENCING A MENTAL HEALTH EMERGENCY.

Emergencies. For emergencies requiring immediate mental health intervention you may:

- Dial 911
- Call the Multnomah County Crisis Line at (503) 988-4888
- Call the Washington County Crisis Line at (503) 291-9111
- Go to the nearest hospital emergency room

You may leave me a message on my voicemail at any time. I check my messages several times a day Monday through Friday and will return your call as soon as possible. It is important to know that I am not on-call to provide services at all times (e.g. weekends, before 9am and after 5pm). If you cannot wait for my return call, use one or more of the above emergency options.

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Thank you for your interest in working together! I am happy to answer any questions you have.

Consent for Treatment

By signing below, I acknowledge that I have had the chance to discuss with Dr. Kelly the risks and benefits of therapy as well as the confidentiality limits described above. I have been given the opportunity to ask questions and have received a copy of this form. I understand that I am also assuming ultimate financial responsibility for the cost of the treatment.

- *Your signature below also serves as an acknowledgment that you have received the HIPAA notice form described above.*

I acknowledge that I understand the contents of this document and I authorize Jennifer E. Kelly, Psy.D. to provide treatment according to the descriptions provided above to the following person(s):

_____
Please Print Client's Name(s)

_____
Client Signature Date

_____
Client Signature Date

_____
Jennifer E. Kelly, Psy.D. Date
Licensed Clinical Psychologist